

**MassHealth**  
**Skilled Nursing/Home Health Aide**  
**Service Increase Notification**

Member: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date: \_\_\_\_\_

Intermittent Skilled-Nursing Service Increase:

\_\_\_\_\_

Reason for Skilled-Nursing Service Increase:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home-Health-Aide Services Increase:

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Reason for Home-Health-Aide Service Increase:

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\_\_\_\_\_

\_\_\_\_\_

Effective Date of Service Increase: \_\_\_\_\_

Certified Home Health Agency: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

*Commonwealth of Massachusetts • Executive Office of Health and Human Services • Division of Medical Assistance*